PATIENT DATA FORM

First Name:	
Middle Initial:	
Last Name:	
Nickname:	

Social Security# - last 6 digits only:	
Date of Birth:	
Age:	
Gender:	Male O Female O

Employer:	
Mail Code:	
Work Phone:	
Cell Phone:	
Home Phone:	
Fax:	

Building/Room:	
Shift:	O 1 O 2 O 3 O TDY
Job Description:	
Supervisor's Name:	
Supervisor's Phone:	

Work email: _____

Have you ever been to RehabWorks before?: YES O NO O

Place injured: O Home O Work O Sport O Other

Is this a Workers' Comp Injury: YES O NO O

COMPLETE THIS SECTION *ONLY* IF THIS IS A WORKERS' COMP INJURY

Workers' Comp Name:	
Workers' Comp Phone:	
Workers' Comp Fax:	

Statement of Consent for Release of Information

I authorize RehabWorks to release the medical information contained in my patient records pertaining to the workers' compensation injury for which I am currently being treated by RehabWorks to my physician and/or workers' compensation representative for the purpose of progress notes and/or case management.

Employee Signature _____ **Date** _____

Medical History Form

Name: _____ **Date:** _____

Do you currently have or have you had problems with:

Select one		Please provide details
◯ Yes ◯ No	Angina/Chest pain	
◯ Yes ◯ No	Arthritis	*Area(s):*
◯ Yes ◯ No	Asthma	
◯ Yes ◯ No	Back Injury	*Type:*
◯ Yes ◯ No	Balance problems	
◯ Yes ◯ No	Blackout/Fainting	
◯ Yes ◯ No	Bleeding problems	
◯ Yes ◯ No	Blood clots or Phlebitis	
◯ Yes ◯ No	Bone Fractures	*Area(s):*
◯ Yes ◯ No	Cancer	*Area(s):*
◯ Yes ◯ No	Cardiac Catheterization	
◯ Yes ◯ No	Cough	
◯ Yes ◯ No	Diabetes	*Type:*
◯ Yes ◯ No	Dislocation/Subluxation	*Area(s):*
◯ Yes ◯ No	Epilepsy/Seizures	
◯ Yes ◯ No	Gout	*Area(s):*
◯ Yes ◯ No	Heart Attack	
◯ Yes ◯ No	Heart Failure	
◯ Yes ◯ No	Heart Murmur	
◯ Yes ◯ No	Heart Valve problems	
◯ Yes ◯ No	Heartburn	
◯ Yes ◯ No	Hepatitis/Jaundice	
◯ Yes ◯ No	Hernias	*Area(s):*
◯ Yes ◯ No	High Blood Pressure	
◯ Yes ◯ No	Infectious Disease	
◯ Yes ◯ No	Kidney problems	
◯ Yes ◯ No	Migraines/Headaches	
◯ Yes ◯ No	Motor Vehicle Accident	
◯ Yes ◯ No	Neck Injury	*Type:*
◯ Yes ◯ No	Numbness/Tingling	*Area(s):*
◯ Yes ◯ No	Osteoporosis/Penia	
◯ Yes ◯ No	Palpitations	
◯ Yes ◯ No	Prednisone usage	
◯ Yes ◯ No	Prior Cardiac Surgery	
◯ Yes ◯ No	Prostate	
◯ Yes ◯ No	Scoliosis	
◯ Yes ◯ No	Shortness of breath	
◯ Yes ◯ No	Sprain (ligament)	
◯ Yes ◯ No	Stomach ulcers	
◯ Yes ◯ No	Strain (muscle/tendon)	
◯ Yes ◯ No	Stroke	
◯ Yes ◯ No	Tuberculosis	
◯ Yes ◯ No	Other	

Additional Comments: _____

Medical History Form (pg.2)

Injury History

_____ Onset of symptoms

Briefly describe why you're being treated at RehabWorks:

_____

_____

☐ N/A **Medications**

Please list any prescription or over-the-counter medicines that you are currently taking:

_____

_____

☐ N/A **Allergies**

Please list any known allergies to medications:

_____

_____

☐ N/A **Past Surgical History**

Surgery:	Year:	Surgery:	Year:
1. _____	_____	6. _____	_____
2. _____	_____	7. _____	_____
3. _____	_____	8. _____	_____
4. _____	_____	9. _____	_____
5. _____	_____	10. _____	_____

Exercise History

Please select one: ◯ Daily ◯ Weekly ◯ Monthly ◯ Rarely ◯ Never

Type of Exercise/Physical activity: _____

Smoking History

Currently Smoking? ☐ Yes ☐ No _____ packs/day for _____ year(s)

Quit Smoking? ☐ This year ☐ >1 ☐ >5 years ☐ >10 years

Previously Smoked _____ packs/day for _____ year(s)

Medical Hx Reviewed by _____ **MS, ATC, LAT** **Date** _____

Reviewed by Supervising Physician _____ **Date** _____

Outcome Assessment

Patient Name: _____

Your responses to this questionnaire will help your Athletic Trainer and this clinic optimize our treatment services to you and other patients. Your responses will be kept confidential and will not affect your care in any way.

Please complete this form for the specific injury for which you will receive or have received treatment. Answer the questions as best you can. Circle the appropriate response according to the (0 1 2 3 4) scale. You will be asked to update the form upon completion of your treatment.

Thank you for your assistance.

Complete this column on 1st appointment	Critical--------Severe--------Moderate--------Minor--------None 0----------1----------2----------3----------4	Update this column upon discharge
0 1 2 3 4	**General health -** feel good, happy, energetic, active, relaxed, free of medication, free of pain/discomfort, good appetite, desired body weight.	0 1 2 3 4
0 1 2 3 4	**Specific medical condition -** current injury/surgery for which we are treating you.	0 1 2 3 4
0 1 2 3 4	**Daily living activities -** sleeping, sitting, standing, walking, climbing stairs, dressing, personal care, driving.	0 1 2 3 4
0 1 2 3 4	**Work activities -** lifting/lowering, holding/handing, carrying, pushing/pulling, bending over, squatting, kneeling, crawling, reaching, turning/pivoting, gripping/pinching, typing/computer, stair climbing.	0 1 2 3 4
0 1 2 3 4	**Sports/recreation/wellness activities -** running, jumping, throwing, catching, kicking, swinging, weightlifting, specific sport/recreation/wellness activity.	0 1 2 3 4

****** *AT TIME OF DISCHARGE* ******

Very UnSatisfied-------Unsatisfied-------Satisfied-------Very Satisfied

0----------1----------2----------3

Satisfaction with treatment services/facilities	0 1 2 3
Satisfaction with Licensed Athletic Trainer	0 1 2 3